

Otis Health Care Center P.O. Box 216 Townshend, Vermont 05353-0216

Phone 802-365-7920 **income tax form must be attached**

MR Number & Account Number to be completed by PPM personnel		MR Number:	Hospital:	Account Number:
Please provide the following information completely and accurately. Information is subject to verification. Please attach a list of additional household members if there are more than five (5) members.				
Patient's Name:		Social Security Number:		Total # Household Members:
Address:			Telephone Numbers: Home: () () Work: () ()	
City/ST/Zip:			Employer(Patient/Responsible Party)	
List ALL household member names	Date of Birth	Soc Sec Number	Relationship to Pt	Monthly Income
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
Monthly Income			Monthly Expenses	
Responsible Party's Gross Income (before taxes)	\$	Rent/Mortgage/Homeowner's Insurance	\$	
Other household Gross Income (before taxes)	\$	Utilities (Electricity/Water/Gas)	\$	
Investment Income	\$	Telephone	\$	
Child Support/Alimony Received	\$	Child Support /Alimony Paid	\$	
Rental Property Income	\$	Food (excluding cigarettes & alcoholic beverages)	\$	
Pension/Retirement/Unemployment	\$	Car Pymt (loan + insurance)	\$	
Other:	\$	Medical & Pharmacy Bills	\$	
Total Monthly Income (before taxes)	\$	Total Monthly Expenses	\$	
Assets			Liabilities	
Value of residence(s)	\$	Residence Loan Balance/Mortgage	\$	
Checking Account Balance	\$	Balance Owed on Credit Cards	\$	
Savings/Money Market	\$	Auto Loan Balance	\$	
Value-Auto/Boat/Motorcycle	\$	Total Medical Bills	\$	
Other	\$	Real Estate Taxes	\$	
Total Value of Assets	\$	Total Liabilities	\$	

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient. I understand that providing false information will result in denial of the application for any type of financial assistance through Otis Health Care Center. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Otis Health Care Center to obtain such assistance and will assign to Otis Health Care center, and upon receipt will pay Otis Health Care, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Otis Health Care Center will result in the denial of this application

Signature of Patient (Responsible Party) _____ Date _____

HAVE YOU APPLIED FOR MEDICAID Y OR N IF SO WHY WERE YOU DENIED